State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CHRISTINE TODD WHITMAN
Governor

WILLIAM WALDMAN
Commissioner

MEDICAID COMMUNICATION NO. 98-7 **DATE:** March 6, 1998

TO: County Welfare Agency Directors

SUBJECT: Revision of Form PA-1G-NJR2 (Redetermination Form)

The revision of Form PA-1G-NJRC was developed by a joint committee of state and county staff during the year 1997. Subsequently, a draft of this form was distributed at the December 8, 1997 Medicaid Supervisors' Meeting. Major changes in the form concern its general consolidation while still retaining the comprehensive information necessary for redetermining eligibility for Medicaid services to the Aged, Blind or Disabled populations. The form is to be used in redetermining eligibility for institutional care, the Community Care Program for the Elderly and Disabled (CCPED), the AIDS Community Care Alternatives Program (ACCAP), and the Medicaid Waiver Programs. For redetermination the face to face requirement has been waived.

The form has since been formalized and may be utilized upon availability of supplies. As in the past, responsibility for the reproduction and dissemination of the form remains with the counties.

Questions concerning this communication should be referred to the Medicaid field service staff assigned to your county.

Sincerely,

Karen I. Squarrell
Acting Director

KIS:Sa
Enclosure
c: Len Fishman, Commissioner
Susan C. Reinhard, Ph.D., Deputy Commissioner
Department of Health and Senior Services

Karen Highsmith, Director
Division of Family Development

Michele Guhl, Deputy Commissioner
Division of Youth and Family Services

NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
MEDICAID PROGRAMS

APPLICATION AND AFFIDAVIT FOR CONTINUATION OF MEDICAL ASSISTANCE ONLY (AGED, BLIND OR DISABLED) INSTITUTIONAL CARE, CCPED, ACCAP OR MEDICAID WAIVER PROGRAMS

NAME OF APPLICANT: _____ CASE #: _____

RESIDENCE ADDRESS: _____

AUTHORIZED AGENT: _____ TEL. #: _____

ADDRESS: _____

IMPORTANT: **The law prohibits duplication of assistance. Applicants receiving Medicaid through the Supplemental Security Income (SSI) Program are ineligible for Medical Assistance through this program.**

INSTRUCTIONS: **This form is to be completed by the applicant whenever possible. If it is necessary for someone other than the applicant to complete or assist in completion of this form, note that the word "you" is used to mean the applicant. PLEASE PRINT.**

Note: **The submission of Social Security Numbers (SSN) is mandatory in accordance with 42 USC 1320b-7. Your SSN will be used to check the identity of household members, prevent duplicate participation and to facilitate making mass changes. Your SSN will also be used in computer matching and program reviews or audits to make sure you are eligible for Medicaid. These procedures are designed to identify persons who fraudulently or wrongfully participate in the Medicaid programs. Such persons may be subjected to criminal action, administrative claims and/or possible loss of all benefits.**

1. **Applicant's Name** _____ SS #_____
(Last) (First) (MI)

2. **Mailing Address:** _____ Tel. #:_____
(Show only if different from residence address shown above)

3. **Income:** List source and last monthly amount. If received at intervals other then monthly, or if this was a one-time receipt, state the interval or date of receipt. Includes, **but is not limited to,** such items as employment income, Social Security benefits, Veteran's benefits, pensions, court ordered support, alimony, Trust Fund payments, property rent, Annuity Benefits, winnings, interest/dividends from stocks, bonds, bank accounts, etc. Attach a copy of the last check received or other acceptable form of verification.

Source	Last Monthly Amount	Interval/Date of Receipt

4. **Resources:** List name of asset, location, account or certificate number (or other identifying information) and value as of the last current month. This includes, **but is not limited to,** savings accounts, checking accounts, certificates of deposit, trust funds, IRA/Keogh Accounts, US Savings Bonds, ownership of mortgages or land, Personal Needs Allowance Fund, Burial Funds. Inheritances, etc. Attach a copy of the last verification of the value of the item.

Name of Asset	Location	Account #	Current Value

6. Have you applied for, started or stopped receiving SSI benefits since your last eligibility review? Yes ☐ No ☐ If yes, explain:

_____

Do you plan to continue living in New Jersey? Yes ☐ No ☐ If no, explain:

_____

7. List name and relationship to you of other members of your household. If the individual is your spouse, show the monthly amount and source of income of the spouse, as well as resources held in his/her name. Attach verification of this income and/or resources.

Name	Relationship	Income/Resources (If spouse)

8. Do you have any medical bills incurred since your last determination of eligibility which remain unpaid? ☐ No ☐ Yes If yes, explain and attach copies of the bill and the Explanation of Benefits form you received from your medical insurance carrier:

_____

_____

9. Have you or your spouse bought, sold, transferred or given away any property since your last eligibility determination?

☐ No ☐ Yes If yes, explain: _____

_____

10. Indicate changes which have occurred since your last eligibility determination, or which you anticipate to occur within the next year. Check all boxes which apply, and briefly describe the change or anticipated change. Add a separate sheet of paper if necessary for explanation.

☐ Residency	☐ Marital Status	☐ Health Insurance	☐ Disability
☐ Liquidation of resource	☐ Income	☐ Household Composition	☐ Employment
☐ Burial Arrangements	☐ Life Insurance	☐ Litigation	☐ Other

_____

_____

BEFORE YOU SIGN, READ THE STATEMENTS BELOW. IF YOU DO NOT UNDERSTAND OR HAVE ANY QUESTIONS, PLEASE ASK!!!

- I agree that the statements made on this form are true and complete to the best of my knowledge. I know that lying about my situation, failing to give necessary information or causing others to hold back information is against the law and may subject me to prosecution. I understand that any information I give is subject to verification by the County Welfare Agency and/or other agencies or officers of the Division of Medical Assistance and Health Services (DMAHS).
- I hereby authorize the County Welfare Agency and/or the State DMAHS to contact any individual or other source who may have knowledge about my circumstances (to include IRS, Social Security Wage and Benefit files, State Wage and Unemployment files, and/or credit reporting services), for the sole purpose of verifying the statements I have made.
- I know that any information I give will be used only in connection with my application for, and receipt of, Medicaid benefits.
- I understand that Medicaid benefits received after age 55 may be reimbursable to the State of New Jersey from my estate.
- I agree to let the County Welfare Agency and/or the State DMAHS know immediately of any change in living arrangements, family situation or money received from any source. If disabled, I agree to report any improvement in my medical condition.
- I understand that as a condition of eligibility for medical assistance, it is deemed that I have assigned to the Commissioner of Human Services, any rights to support for the purpose of medical care as determined by a court or administrative order and any rights to payment for medical care from any third party.
- I understand that I may request a Fair Hearing if I am not satisfied with any action taken by the County Welfare Agency or State DMAHS.
- I understand that I will not be discriminated against because of race, color, religion, sex, handicap, national origin or marital, parental or birth status.
- I, by signing below, attest that I have read and agree to these statements and fully realize that the County Welfare Agency and/or the State Division of Medical Assistance and Health Services rely upon the truth and accuracy of my statements.

_____ _____

(Applicant's Signature or printed name if signed by authorized representative) (Date)

_____ _____

(Signature of Authorized Representative) (Date)

_____

(Relationship to applicant)

SWORN AND SUBSCRIBED BEFORE ME THIS _____DAY OF _____, 19____.

_____

(County Welfare Agency representative)